

The Right to Treatment—An Enchanting Legal Fiction?

Jay Katz†

The involuntary confinement of the “mentally ill” creates disquieting tensions for a society which in other ways of life values the liberty of the individual. Opposing wishes to neglect and to care, to protect and to abandon can be identified in involuntary commitment proceedings; therefore, no conflict-free resolution of the problems inherent in such deprivations of liberty is possible. Recently, in order to mitigate the deprivations suffered, the District of Columbia Circuit Court of Appeals in *Rouse v. Cameron*¹ has invoked the principle that individuals so confined have an enforceable “right to treatment.” Some of the possible consequences of this “right,” however, bring into sharper focus the uneasiness about current practices of involuntary commitment.²

To the extent to which deprivations of liberty for “mental illness” are increasingly justified on the basis of “being in need of treatment,” the danger is very real that the right to treatment not only will serve the purpose of improving therapeutic opportunities but also will further support, or even aggravate, existing indiscriminate practices of incarceration on therapeutic grounds. If a right to treatment is to escape this fate, its ambit must be carefully defined, especially once treatment is elevated to a constitutional right.³

† Professor (Adjunct) of Law and Psychiatry, Yale University. This article was presented, in part, at a Wayne State University Law School Symposium on The Mentally Ill and the Right to Treatment, April 17, 1969.

¹ 373 F.2d 451 (D.C. Cir. 1966). Charles Rouse was involuntarily committed to Saint Elizabeths Hospital. He had been found not guilty by reason of insanity of carrying a loaded pistol and 600 rounds of ammunition, a misdemeanor for which the maximum imprisonment is one year. After more than three years of confinement, Rouse brought a habeas corpus action, alleging among other grounds that he was not receiving any treatment. The district court ruled that failure to provide treatment was not a basis for relief in habeas corpus. On appeal, the District of Columbia Circuit Court of Appeals reversed and remanded.

² In this paper, except when specifically indicated, involuntary confinement will include involuntary civil commitments and commitments following acquittal by reason of insanity. Most of the problems posed by a “right to treatment,” as Chief Judge Bazelon asserted in *Rouse v. Cameron*, apply to all persons who are involuntarily committed.

³ While in *Rouse v. Cameron* the right to treatment was justified in terms of the statutory language, the court also noted: “Absence of treatment ‘might draw into ques-

In granting "the right to treatment" to Rouse and others in situations of enforced confinement, the court did not address itself to an analysis of the implications of such a right for patients and instead turned its attention to the conditions which hospitals must meet once incarceration is justified on therapeutic grounds. Perhaps this is all that the court had to do in this case, since the petitioner had claimed that "as far as treatment is concerned, he is receiving none."⁴ But, how should hospitals and courts respond in a case similar to *Rouse v. Cameron* where the person, for example, refuses treatment? At least the following alternatives could be considered: to keep the person in the hospital and wait until he is ready to accept treatment; to employ coercive methods or treatment which do not require his cooperation; to gain acquiescence to treatment by coercive "therapeutic" interventions; to release him; or to make other custodial dispositions.

Thus, questions, like the following, about the relationship between rights and duties must soon arise: Does the right impose only a correlative duty on the state and the mental health profession to provide treatment for those persons who wish to exercise such a right? Or does this right also impose a duty on the person to submit to treatment? If the former, what are the consequences for those who do not wish to invoke such a right or are unlikely to benefit from treatment? If the latter, what kinds of treatment can and should be authorized for those who do not wish to be treated, and, again, what are the consequences for those who are unlikely to benefit from treatment?⁵ Rights may impose corresponding duties on the individual, but distinctions should be made between rights which a person can waive and those he cannot waive.⁶

tion the constitutionality of [this] mandatory commitment section as applied.'" 373 F.2d at 453. However, in *Nason v. Superintendent of Bridgewater State Hospital*, — Mass. —, 233 N.E.2d 908, 913 (1968), the Supreme Court of Massachusetts based the right to treatment on constitutional grounds rather than statutory provisions.

⁴ 373 F.2d at 461.

⁵ For those who are unlikely to benefit from treatment further questions arise: e.g., after how long a period of therapeutic trial should this determination be made; should the length of a therapeutic trial depend on the nature of the "mental illness" and/or the kind of "dangerousness"; what are the consequences if the patient, the psychiatrist, or both agree or disagree that treatment has little or nothing to offer?

⁶ H.L.A. Hart states that "[i]f there are legal rights which cannot be waived these would need special treatment." Hart, *Definition and Theory in Jurisprudence*, 70 LAW Q. REV. 37, 49 n.15 (1954). In his discussion of legal rights Hart emphasizes the importance of considering

... the choice which is open to one who has a right as to whether the corresponding duty shall be performed or not. For it is, I think, characteristic of those laws that confer rights (as distinguished from those that only impose obligations) that the obligation to perform the corresponding duty is made by law to depend on the choice of the individual who is said to have the right or the choice of some person authorized to act on his behalf.

I would, therefore, tender the following as an elucidation of the expression "a

Such distinctions are of crucial importance both for purposes of treatment and public policy. For example, a duty to be treated and a duty to treat are meaningless duties whenever motivation is a precondition for treatment or a person is untreatable. It may be a duty the state will not wish to enforce whenever manipulation of behavior, "therapeutic" efforts at social control, or irreversible surgical procedures exceed certain limits.⁷ The doctrine of "the right to treatment" as articulated by the District of Columbia Circuit Court of Appeals does not make such distinctions, and the question must be posed whether the right to treatment, despite its commendable goals, conflicts with other fundamental, though often disregarded, assumptions of law and psychiatry.

If not in theory, then surely in practice, a legally imposed duty to be treated and to treat has been the rule for a long time,⁸ and it has been unquestioningly accepted, even invited, by the psychiatric pro-

legal right": (1) A statement of the form "X has a right" is true if the following conditions are satisfied:

- (a) There is in existence a legal system.
- (b) Under a rule or rules of the system some other person Y is, in the events which have happened, obliged to do or abstain from some action.
- (c) This obligation is made by law dependent on the choice either of X or some other person authorized to act on his behalf so that either Y is bound to do or abstain from some action only if X (or some authorized person) so chooses or alternatively only until X (or such person) chooses otherwise.

(2) A statement of the form "X has a right" is used to draw a conclusion of law in a particular case which falls under such rules.

Id. at 49.

F.K.H. Maher's warning further emphasizes the need for distinctions between rights and duties:

[I]t is not wise to overstress duties. Sir Carleton Allen pointed this out in a review in 1929 of Pollock's *Jurisprudence*. He saw the dangers in primary emphasis on duties. "One's only right is to do one's duty." Totalitarian regimes have since shown themselves so careless of human rights, so clamorous about duties to the State, that we have had to write out fresh Charters of Human Rights to redress the balance. Since with us the State is an instrument of the human persons within it, and since these persons require certain rights to achieve the fullness of their personality, legal rights are seen as the true basis of human freedom.

Perhaps the most dangerous result of concentrating on duty is that some people come to feel that since the test of some rights is whether there are corresponding duties, therefore the duty creates the right. The law, they seem to say, operates only by setting up duties: if you cannot find a duty then there can have been no right. I would prefer to think that our system exists to protect rights and that imposing duties is its method of seeing that rights are made precise and that someone must do something specific about them.

Maher, *The Kinds of Legal Rights*, 5 MELBOURNE U.L. REV. 47, 67 (1965).

⁷ See text at note 64 *infra*.

⁸ "The most frequently asserted ground [for civil confinement] is society's right, if not duty, to commit for treatment people so mentally disordered as to be unable to decide whether to seek treatment themselves." Comment, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967). However, it is not at all clear how far a duty to submit to which kinds of treatments should extend. Perhaps, except for acute psychiatric disorders, the duty should be limited to an exploration of the person's resistances to treatment in an effort to understand them. This could lead to an acceptance of treatment or to greater clarity about the reasons for its rejection. See text at notes 55-56 *infra*.

fession. Unless this duty is carefully scrutinized, it will cast a malignant shadow on the positive objectives of the right to treatment. Analysis of how the "duty" distorts these objectives will be the first task of this paper. Even if a duty to be treated can be justified, we must still ask whether and how the corrupting propensities of such coercion can be mitigated; this will be the second task of this paper.

I. THE OBJECTIVES

A. *Safeguarding the Legal Process*

It is not surprising that the District of Columbia Circuit Court of Appeals affirmed the right to treatment once the issue was brought before it. Ever since *Durham v. United States*⁹ and the many decisions which followed, such a promulgation could have been predicted.¹⁰

Absent treatment, the justification for indeterminate commitment after an *acquittal* by reason of insanity or following civil commitment proceedings rests primarily on the rationale of preventive detention.¹¹ Its general application has, however, been resisted,¹² because preventive detention has always been viewed as too tempting an instrument for the abuse of power and in conflict with a belief in incarceration only after conviction. But law has specifically sanctioned such detentions for persons adjudged to be of "unsound mind." It has been justified for the mentally ill as serving primarily the "patient's" and only secondarily society's welfare; though society's interest is clearly evident from the prevailing public image that mentally ill persons are more dangerous to others than ordinary persons or criminals.¹³ In recent years, however, serious objections have been raised about such a stereo-

⁹ 214 F.2d 862 (D.C. Cir. 1954).

¹⁰ For example, in *Williams v. United States*, 250 F.2d 19 (D.C. Cir. 1957), the court stated:

Two policies underly [*sic*] the distinction in treatment between the responsible and the non-responsible: (1) It is both wrong and foolish to punish where there is no blame and where punishment cannot correct. (2) The community's security may be better protected by hospitalization . . . than by imprisonment. . . . Hospitalization . . . would serve the dual purpose of giving him the treatment required for his illness and keeping him confined until it would be safe to release him. . . .

Id. at 25-26.

¹¹ "[The insanity defense] fuses criminal law with a species of administrative law, shifting the defendant from a criminal process to a civil-medical one which explicitly incorporates elements of preventive detention. . . ." A. GOLDSTEIN, *THE INSANITY DEFENSE* 20 (1967).

¹² *But see* Dershowitz, *On "Preventive Detention,"* 12 N.Y. REVIEW OF BOOKS 22 (March 13, 1969).

¹³ Statement of Dr. Francis Braceland and Dr. Jack Ewalt, *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 87th Cong., 1st Sess. 84 (1961) [hereinafter cited as *1961 Hearings*].

typical image of the mentally ill,¹⁴ about the ability of the psychiatric profession to predict future dangerousness on so broad a scale¹⁵ and about the lack of a definition of dangerous behavior¹⁶ which should invoke such an extreme sanction. In case and commentary it is recognized that commitment to a mental hospital solely on the ground of predicted dangerousness raises troublesome problems for the administration of law¹⁷ and, if sanctioned, requires extensive substantive and procedural reforms.

To avoid this reexamination of the commitment process, the therapeutic intent of involuntary commitments has been increasingly emphasized, in the hope that by such a shift of emphasis the uneasiness about preventive detention could be laid to rest. The uneasiness, however, could only be reduced because even with the best of treatment the reality of preventive detention could at most be denied but not obliterated. The anxieties emerged again in full force once the absence of adequate therapeutic facilities had to be faced. Chief Judge Bazelon recognized that without treatment the rationale for hospitalization would be seriously undermined: "[T]he purpose of involuntary hospitalization is treatment Absent treatment the hospital is 'transform[ed] . . . into a penitentiary where one could be held indefinitely'"¹⁸

However, the problem is not only indefinite commitment, but commitment altogether. Conceptually an acquittal by reason of insanity should lead to release,¹⁹ and if deprivation of liberty can be justified at

¹⁴ "The fact is that the great majority of hospitalized mental patients are too passive, too silent, too fearful, too withdrawn" to be dangerous. Statement of Albert Deutsch, 1961 *Hearings*, *supra* note 13, at 43.

¹⁵ Dershowitz, *On "Preventive Detention,"* 12 N.Y. REVIEW OF BOOKS 22, 26 (March 13, 1969).

¹⁶ Katz & J. Goldstein, *Dangerousness and Mental Illness—Some Observations on the Decision to Release Persons Acquitted by Reason of Insanity*, 131 J. NERVOUS & MENTAL DISEASE 404, 410 (1960) (also published in 70 YALE L.J. 225 (1960)) [hereinafter cited as Katz & Goldstein].

¹⁷ See generally A. GOLDSTEIN, *THE INSANITY DEFENSE* (1967). Frankel, *Preventive Restraints and Just Compensation: Toward a Sanction Law of the Future*, 78 YALE L.J. 229 (1968). For cases, see J. KATZ, J. GOLDSTEIN & A. DERSHOWITZ, *PSYCHOANALYSIS, PSYCHIATRY AND LAW* ch. 2 (1967).

¹⁸ *Rouse v. Cameron*, 373 F.2d 451, 452-3 (D.C. Cir. 1966).

¹⁹ Katz & J. Goldstein, *Abolish the Insanity Defense—Why Not?*, 138 J. NERVOUS & MENTAL DISEASE 57, 60 (1964) (also published in slightly altered form in 72 YALE L.J. 853 (1963)). Recently the District of Columbia Court of Appeals questioned the mandatory commitment provisions (D.C. CODE ANN. § 24-301(d) (1967)) which follow an acquittal by reason of insanity. The court ruled that "persons found not guilty by reason of insanity must be given a judicial hearing with procedures substantially similar to those in civil commitment proceedings. . . . Commitment will result if the court finds, by the preponderance of the evidence, that the person is likely to injure himself or other persons 'due to mental illness.'" *Bolton v. Harris*, 395 F.2d 642, 651 & n.50 (D.C. Cir. 1968).

all, it can only rest on a need for treatment, at least until preventive detention as a consequence of such acquittals is specifically authorized. Similar considerations apply to most civil commitments²⁰ since they, too, are preventive detentions made more palatable by focusing on the need for treatment. Thus it becomes clear that the right to treatment as promulgated by the District of Columbia Circuit Court of Appeals also serves the purpose, however inadequately, of protecting the internal logic of the decisions beginning with *Durham v. United States*.²¹

To identify such a purpose would only be of academic interest if the right to treatment had been granted only to those who wish to exercise it and the consequences for those who did not wish to invoke it had been clearly articulated. But it remains unclear whether the right to treatment only imposes a duty on the hospital to provide treatment opportunities or whether it also imposes a duty to be treated.²² If the latter, the consequences for those who cannot be treated or for whom no effective treatment is as yet available must be disclosed. Otherwise it could become a "right" which can be exercised unto death as long as there is a glimmer of hope of rehabilitation in the eyes of judges and therapists. As long as the right to treatment remains so closely and indiscriminately tied to involuntary treatment and indeterminate detention, the real danger exists that society will continue to abuse the individual in the name of safeguarding his welfare, never acknowledging the equally strong wish to keep him safely tucked away. The duty to treat and be treated can readily serve society's unacknowledged defensive needs to deny and repress the uneasiness about commitment solely for purposes of preventive detention which remains a reality

²⁰ Statutory criteria for civil commitment process include persons who are mentally ill and dangerous to themselves or others and/or those who are mentally ill and in need of care, custody, or treatment. For a discussion of standards applied in the various states, see AMERICAN BAR FOUNDATION, *THE MENTALLY DISABLED AND THE LAW*, 17, 44-51 (1961).

²¹ Already in *Ragsdale v. Overholser*, 281 F.2d 943 (D.C. Cir. 1960), Judge Fahy stated: "[T]here is a rational relationship between mandatory commitment . . . and an acquittal by reason of insanity. . . . But this mandatory commitment provision rests upon a supposition, namely, the necessity for treatment of the mental condition which led to the acquittal by reason of insanity. And this necessity for treatment presupposes in turn that treatment will be accorded." *Id.* at 950 (concurring opinion).

²² This is an especially important issue for persons acquitted by reason of insanity. The judgment that they are "competent to stand trial" at least raises the question whether they should not be considered competent to participate in decisions about treatment. Civilly committed persons, e.g., "sexual psychopaths," addicts, and at least some who for reason of "mental illness" are viewed as "dangerous" to themselves or others, may have the same capacity. If there is doubt about such competence, proceedings need perhaps be established for determining (1) competence to participate in decisions about treatment and (2) if incompetent, the likelihood of any authorized treatment being effective under these circumstances. See notes 60 & 71 *infra*.

under the District of Columbia Circuit Court of Appeals' promulgations—at least for those persons on whom we do not wish to impose therapy against their will or who cannot benefit from treatment.

B. *Protecting the Individual's Need for Adequate Treatment*

Protection of the right to adequate treatment could be construed narrowly as a judicial guarantee that those who seek treatment will in fact receive it. The right would then encompass only those who enter hospitals either well motivated for treatment or who are willing to explore the benefits which therapy might provide because they themselves have become bewildered and troubled by their behavior. Few problems would arise if the right to treatment were to apply only to this group, though such issues as length of treatment, consequences of interruption of treatment and, above all, delegation of authority to select methods of treatment would have to be carefully studied.

However, strict limitation of the right to treatment to those who from the outset consciously ask for therapy must be evaluated against the reality of psychological behavior. Man may consciously seek one solution to his problems and unconsciously hope for another. It is not rare to observe such conflicts in a person which preclude his asking for treatment; yet once it is imposed, he readily or gradually accepts.²³ The dangers inherent in acting on behalf of others from inferences about non-conscious wishes are great. Yet, if these wishes are disregarded or rejected by preferring to act only on conscious messages,

²³ A patient, prior to her initial encounter with Dr. Will, had spent eighteen months in another hospital where she had become increasingly more assaultive and afraid of others. "She would wear no clothing other than an old dressing gown, resisted bathing, frequently burned herself with cigarettes, and was apparently hallucinating." Will, *Process, Psychotherapy, and Schizophrenia*, in *PSYCHOTHERAPY OF THE PSYCHOSES* 10, 25 (A. Burton ed. 1961) [hereinafter cited as Will].

When I first met Miss X she displayed no great enthusiasm for me, psychiatrists in general (or anything psychiatric), having found little in her life so far that reassured her about the benefits of human contacts, professional or otherwise. When I entered her room she was crouched in a corner behind the head of the bed, and drew away as I introduced myself. I spoke quietly, said that I would stay for a while, and seated myself in a chair across the room from her. Miss X kept her back turned to me, and after about ten minutes of silence I said that I knew a little about her previous hospitalization, having read the record, but that I wanted to hear from her what her experiences had been. She suddenly turned toward me, spat on the floor, and told me to get out. I did not leave, but said that I should remain for about an hour, and should return for several such meetings each week on a regular schedule. Miss X then said that she was no good, and that no one could help her. I suggested that there might be a certain extravagance in such statements, and that all I could guarantee was that I should attempt to get some clarity about what had happened to her and what went on between us. For a moment she seemed to be more relaxed, but then became frightened, pointed at her head, and said "I know what you'll do." "No," I said, "we'll do nothing but meet and talk together. There's no insulin or electric treatment here."

"I don't believe you," was the reply, but her tenseness subsided a little.

Id. at 31-32.

equally important non-conscious messages will be left unacknowledged. Thus a decision to listen to non-conscious voices can lead to an abuse of power, while a decision to heed only conscious voices can abandon persons to an unwished fate. It is a dilemma for which there are no simple solutions.

If the right to treatment includes a duty to be treated, it must be realized that to choose the role of patient is always difficult. It is an impossible choice for many whose way of life has been committed to action rather than reflection, to changing the external rather than the inner world or the two together. Persons only become patients once they are willing to accept help and sufficiently trust those who offer it.²⁴ Of course some persons, through medication or physical methods of treatment, can be made patients without their cooperation and relieved of distressing symptoms.²⁵ Sometimes these interventions may be medically indicated as the treatment of choice or as a preparatory step for establishing a collaborative therapeutic relationship. However, their employment in involuntary settings raises long neglected questions for law and psychiatry about the invocation, application, and appraisal²⁶ of such interventions.

Moreover, the right to treatment can encompass those who cannot be motivated to assert such a right and who should not, even if it were possible, be compelled to accept treatment. Whatever the reason, there are persons whose wishes to be left alone should be respected lest the right to treatment become an instrument for the invasion of personality and privacy, which in other areas of life, law seeks increasingly to protect.²⁷

Thus, the right to treatment can become an empty slogan for those who cannot elect it, a compulsory procedure without any choice and meaning for those who persist in rejecting it, or a compulsory procedure inimical to the restraints on the exercise of authority which so-

²⁴ In order not to be blinded by labels, it would be far better not to call "persons" "patients" until a therapeutic relationship has been established. *But see* Millard v. Cameron, 373 F.2d 468, 473 (D.C. Cir. 1966): "Persons against whom proceedings under [the Sexual Psychopath Law] are instituted are called 'patients' because the title essentially provides treatment rather than punishment."

²⁵ Two models of therapy can be distinguished: the psychotherapeutic model which emphasizes verbal interaction between therapist and patient and requires at least some cooperation by the patient; the organic model which utilizes pharmacological agents, electroshock, and other physical interventions, which can be administered and bring about change even without a "patient's" cooperation. For further discussion see text at notes 61-65 *infra*.

²⁶ For a discussion of these categories, see H. LASSWELL, *DECISION PROCESS* (1956).

²⁷ *See* Stanley v. Georgia, 394 U.S. 557 (1969); Griswold v. Connecticut, 381 U.S. 479 (1965); Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

ciety should practice.²⁸ If a person will not, cannot, or should not become a patient, alternatives to treatment and their consequences have to be clearly promulgated.²⁹ Otherwise, the right to treatment introduces the danger of an inevitable duty to be treated akin to thought reform³⁰ or indefinite detention perniciously cloaked by therapeutic "kindness."

C. Preventing Community Neglect

The District of Columbia Circuit Court of Appeals noted that mandatory commitment "is permissible because of its humane therapeutic goals."³¹ Thus a third objective of the right to treatment is to support and nourish society's humanitarian impulses which are so readily prone to compromise and corruption once wishes to love and care meet the demands for allocation of resources. Though all patients, and especially those who are sent to hospitals at the behest of the state, should be provided with adequate opportunities for therapy, the court was aware that such conditions do not now exist and asked for prompt remedial action. But the right to adequate therapeutic facilities, the duty to treat, must not be confused with the right and/or duty to be treated.

²⁸ See, e.g., *Olmstead v. United States*, 277 U.S. 438, 479 (1927) (Brandeis, J., dissenting): "Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding."

²⁹ One of the alternatives could be preventive detention for those "mentally-ill" persons who, though untreatable, are considered sufficiently "dangerous" to themselves or others. However, this policy should be explicitly promulgated so that its constitutionality can be tested, at least with respect to the procedural safeguards which such commitments require.

³⁰ For an interesting discussion of the relationship of therapy to thought reform see R. LIFTON, *THOUGHT REFORM AND THE PSYCHOLOGY OF TOTALISM* (1961):

Since thought reform has its own notion of "resistance," the caricatured exaggerations of ideological totalism can be helpful in examining some of the presuppositions of more moderate and more genuinely therapeutic work. Chinese reformers are apt to consider any inner opposition or outer hesitation—in fact anything at all that stands in the way of thought reform—as "resistance." The psychotherapist similarly regards almost any attitude or behavior standing in the way of cure—but especially the reluctance to bring unconscious ideas into consciousness—to be expressions of resistance to therapy. These resistances are the real experience of any therapist; but after a study of thought reform one cannot help but be a bit chastened in the use of the concept. That is, as a psychotherapist I would consider it important to ask myself whether what appears to be resistance is truly a reflection of inner opposition to cure, or whether it might be inner opposition to my concept of the necessary direction of cure. And I would also wonder whether such resistance might not be a reflection of poor communication between the patient and myself, or of the absence between us of shared values and assumptions about the therapy, both of which might be profitably investigated along with any psychological barriers within the patient.

Id. at 449.

³¹ *Rouse v. Cameron*, 373 F.2d 451, 453 (D.C. Cir. 1966).

Optimal patient-staff ratios, access to a wide variety of therapeutic modalities, and establishment of a human environment, all of which are sorely lacking in most institutions for the mentally ill,³² are prerequisites for treatment which society can provide. They must not be equated with the therapeutic endeavor itself. The right to treatment, if it is to have meaning, requires in addition a person who can exercise such a right or, if treatment is imposed, can benefit from it. Neither the trial record nor the appellate opinion in *Rouse v. Cameron* reflected that Rouse's complaint was based on a desire or capacity for treatment.³³ Indeed the dissenting opinion of Judge Danaher suggests that Rouse did not want treatment or at least could not tolerate the kind he received.³⁴ Perhaps such an inquiry was unnecessary because the court felt that the most crucial issue to be adjudicated was the allegation that he had not been receiving *any* treatment. Yet, in linking the right to treatment with adequate staff and "a bona fide effort" to treat, there is the danger, that once such conditions are met and proof to that effect is submitted, the right to treatment will be construed to rest on the existence of facilities and not on the person's willingness or ability to utilize them.

D. *Encouraging the Mental Health Profession to Promulgate Standards of Care*

The court was aware of the need for "pertinent data concerning standards for mental care"³⁵ and invited the assistance of a number of professional groups to help in establishing these standards. Though neither relevant nor reliable information is available at present, the

³² Dr. Harry C. Solomon, then President of the American Psychiatric Association, stated: "After 114 years of effort, in this year 1958, rarely has a state hospital an adequate staff as measured against the minimum standards set by our Association, and these standards represent a compromise between what was thought to be adequate and what it was thought had some possibility of being realized . . ." Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 AM. J. PSYCHIATRY 1, 7 (1958).

³³ See, e.g., testimony of Dr. Straty H. Economon, a staff psychiatrist at Saint Elizabeths Hospital, who testified in the district court proceedings upon remand of the *Rouse* case: "I came to the conclusion that [Rouse] could not form bonds with people and also that he subscribed to the notion that litigation and extraordinary means of redress were the answer to his problems as he saw them. He would spend time trying to get out by legal means, if you will, as opposed to finding out why he was there, getting some insight and helping himself." *Rouse v. Cameron*, H.C. No. 387-65, transcript at 169-70 (D.D.C. Jan. 12, 1967) [hereinafter cited as Transcript in *Rouse v. Cameron*].

³⁴ 373 F.2d at 462, 465 (dissenting opinion). Judge Danaher noted: "[Rouse] was contending on his pleadings and at trial that he was *not* insane and that he *needed no treatment*. His own expert . . . testified that Rouse was not mentally ill and that he should have been sent to jail in the first place. . . ." *Id.* at 462 (emphasis in original).

³⁵ 373 F.2d at 457.

court's request will force the mental health profession to promulgate more precise criteria for treatability, selection of treatment, cure, lack of therapeutic response, and release. These efforts should reveal the tentativeness of all such promulgations and caution law and psychiatry not to expect "finality of judgment"³⁶ or to rely on it whenever it is advanced.

The decision in *Rouse v. Cameron* left no doubt that the court will review and pass judgment on the adequacy of treatment. No professional group readily accepts supervision by outsiders, and the American Psychiatric Association quickly responded to this unwelcome interference: "The definition of treatment and the appraisal of its adequacy are matters for medical determination."³⁷ By immediately staking out territorial claims, so common in the dialogue between psychiatry and law, more fundamental issues were left unexamined. Most important is the delineation of the authority which the state should delegate to the profession for administering the fate of persons who are involuntarily sent to mental institutions.³⁸ Whenever deprivation of liberty is in issue, it is often not fully realized that law, and not psychiatry, is the ultimate decision-maker. As long as this is not clear, role confusion will intrude on any delegation of authority.³⁹

³⁶ Justice Frankfurter stated in *Greenwood v. United States*, 350 U.S. 366, 375 (1956): "The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment"

³⁷ Council of the American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIATRY 1458 (1967) [hereinafter cited as *1967 Position Statement*].

³⁸ There are matters of "definition of treatment and the appraisal of its adequacy" which should be left to the profession, but in coerced settings it must be clear what role the community should play, and in what form, in the decision-making process. For example, should the community participate not only in resolving issues as to length of treatment, but also as to kinds of treatment? Who decides, once it has been concluded that a lobotomy is the treatment of choice, whether it should be executed; or once intensive psychotherapy is considered the best treatment for a check forger, whether it should be undertaken if it also requires years of hospitalization? Thus questions can be raised about the American Psychiatric Association's declaration: "It is the responsibility of the physician to determine the appropriate treatment techniques to fit the individual patient's physical and psychological needs, assets, and circumstances." *1967 Position Statement*, *supra* note 37, at 1459.

³⁹ For example, in its position statement the American Psychiatric Association declared: "It would manifestly be 'poor treatment' to release a patient to commit an unlawful act." *1967 Position Statement*, *supra* note 37, at 1458. Such an assertion could have been useful to lawmakers if it had been followed by a definition of an unlawful act for purposes of indefinite commitment, standards for predicting the likelihood of such an act recurring, or criteria for release which might be either "good" or "poor" treatment from the various vantage points of the community, the psychiatrist, and the patient. However, in contemplating such definitions, standards, and criteria as well as the role which law must play in the process, the American Psychiatric Association might have

The coolness of the American Psychiatric Association toward the court's pronouncements on the right to treatment may be based on the realization that the profession will have to articulate standards and predictions about treatment and release in coerced settings that psychiatrists have so far not advanced.⁴⁰ Too often they fall back on: "I do not believe we ought to write off any patient as incurable. . . . In other words, we are going to try our hand at treating every patient that is sent to us."⁴¹ It is ironic that after a long history of agitation by psychiatrists to wrest persons from the criminal process because they are "mentally ill" and "in need of treatment," they are now uneasy about the obligation to set forth their own substantive and procedural guidelines which a call for authority to rehabilitate makes unavoidable.⁴²

The court must have been aware of the extent and limits of therapeutic knowledge. Yet, surprisingly, it relegated to a footnote and left unconsidered the crucial problem of the untreatable patient: "We need not now resolve the implications of the 'right to treatment' for a patient who is demonstrated by the hospital to be 'untreatable' in the present state of psychiatric knowledge, if such a patient exists."⁴³

realized that it need not make such a statement in the first place. The decision to release a person "to commit an unlawful act" is a societal judgment to which psychiatrists as experts can only contribute relevant data. Thus the American Psychiatric Association could have asked law instead: Under what circumstances should psychiatrists not release patients if there is what probability that they will commit what kind of unlawful acts? See generally Katz & Goldstein, *supra* note 16.

⁴⁰ For a variety of opinions on adequacy of treatment, see report of discussion at the 20th Mental Hospital Institute, in 6 *FRONTIERS OF HOSPITAL PSYCHIATRY* No. 4 (Feb. 15, 1969).

⁴¹ Statement of Dr. Winfred Overholser, then Superintendent of Saint Elizabeths Hospital, 1961 *Hearings*, *supra* note 13, at 594.

⁴² It is difficult to articulate standards for treatment of choice, cure, and fitness for treatment in voluntary therapeutic settings and even more so in coerced ones. Whenever a prospective patient consults a psychiatrist for therapy in private settings, these issues can be discussed during the initial interviews and throughout treatment. Indeed, once they are brought under scrutiny it becomes clear how tentative any answers have to be. Against the background of options to continue, interrupt, or terminate therapy at any time, with or without the approval of the therapist or patient, explorations of the purpose and meaning of treatment can proceed more freely and become, as they must, an integral part of the therapeutic process. Such discussions and decisions become more difficult, if not impossible, in coerced settings. Doubts about motivation will become muted because they may suggest lack of commitment to change. Therapeutic progress will be viewed with suspicion by the patient because he cannot be sure whether he is acquiescing to "change" in order to gain release or whether he has learned something new about himself. The therapist will be equally suspicious because he will find it difficult to distinguish between "insight" and "simulation." Thus the therapeutic encounter will become contaminated by the coercion, and patients as well as therapists will antagonistically rather than mutually question each other as to whether treatment is succeeding or has succeeded, is failing or has failed.

⁴³ 373 F.2d at 457 n.28.

He does indeed exist, and the court must have known this.⁴⁴ Moreover, the court must have been aware that predictions about treatability and outcome of treatment are least reliable when motivation is also in issue, that such uncertainties can last for years, and that therapists may be unwilling or unable to treat some patients. All these issues have significance for decisions to release or not release patients from hospitals. In the absence of any court-created standards, psychiatrists are placed in the difficult position of making decisions alone that allow not only release based on therapeutic success, but also confinement based on doubts about progress, minimal progress, or therapeutic failure.⁴⁵ Release is a societal judgment, to which psychiatrists can only make specific clinical contributions, and lawmakers must instruct psychiatrists about their obligations to the community and patients with respect to releasing and detaining patients they can or cannot, wish or do not wish to treat.

II. ABOUT COERCION

The duty to be treated, which is an integral part of the right to treatment as presently promulgated by the District of Columbia Circuit Court of Appeals, can be either enforced or rejected. If totally rejected, a fundamental reexamination of civil and criminal commitment proceedings for the "mentally ill" becomes unavoidable because involuntary commitment rests on a coercion to be treated, though without the additional safeguards which a right to treatment could introduce. If the necessity of coercion is accepted, the questions must be posed and answered: Why, for whom, and within what limits?

Commenting on institutions from the vantage point of the non-patient Goffman states: "If all the mental hospitals in a given region were emptied and closed down today, tomorrow relatives, police, and judges would raise a clamor for new ones; and these true clients of the mental hospital would demand an institution to satisfy their needs."⁴⁶

⁴⁴ During a talk at the Harvard Law School on November 1, 1966, Chief Judge Bazelon first suggested that "all patients are treatable" but then admitted that "[t]his may be a legal fiction." 80 HARV. L. REV. 898, 900 (1967).

⁴⁵ Of course, psychiatrists could face the court with release applications and thus prompt a series of decisions giving substantive content to "untreatability" and its consequences. In the light of past performance, this is an unlikely expectation. During the hearings in *Rouse v. Cameron*, Dr. Dale C. Cameron, then Superintendent of Saint Elizabeths Hospital, candidly admitted that therapeutic opportunities are inadequate at his hospital. Transcript in *Rouse v. Cameron*, *supra* note 33, at 13-18. Subsequent to the decision of the District of Columbia Circuit Court of Appeals, Cameron could have considered submitting applications for release with respect to patients his staff was unable to treat because of lack of adequate facilities.

⁴⁶ E. GOFFMAN, *ASYLUMS—ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* 384 (1961).

Yet, the non-patient's wish to coerce, to hospitalize, is a mixture of many needs, including concern, frustration, care, rejection, compassion, anger, affection, and hostility toward those to whom one is ambivalently tied and from whom one is ambivalently separated. Patients, on the other hand, often view involuntary hospitalization only as an unwarranted coercion and such convictions cannot be disregarded even if they seem "irrational."

The reality of coercion will remain part of the fabric of society and will always haunt us; though we cannot eradicate it, we must learn to minimize it. Life without such coercions is difficult to envision. People will suddenly undergo a radical change in behavior and become panicky, self-destructive, or violent;⁴⁷ others will become more gradually depressed, withdrawn, or delusional; and still others will embark on anti-social activities which they can neither explain or understand. Whatever the behavior, many persons cannot consciously acknowledge the need for protection and treatment. Some who might be convinced that they are undeserving of such a privilege. What weight should be given to these protestations, when we also appreciate that all, or at least some, who utter them are influenced by convictions that no one wishes to help them? For some the world has always been or has suddenly become enemy territory populated by prosecutors and persecutors bent on destroying them, and some believe that they themselves are worthless and undeserving of life. These convictions can be very powerful and often are not amenable to correction by the mere offer of help which leaves to the person the choice to accept or reject it.

Few persons involuntarily committed to mental hospitals by either civil or criminal proceedings are aware of being in need of treatment. Instead they blame past and present behavior on parents, spouses, friends, neighbors, institutions, and society. While there is often considerable truth to such feelings, they cannot appreciate how external conditions have combined with internal ones to fundamentally affect their actions and reactions. They assert that if the world around them would change or respond more appropriately to their needs, they would not get into further trouble, though the time when this alone might have been sufficient belongs to a distant past. They perceive only dimly, if at all, that now the world within them compels them to

⁴⁷ One night, after a number of weeks of fearful suffering, as I was lying in bed tossing, sleepless and despairing, a most horrible impulse seized upon me, an impulse impelling me to destroy one who of all living beings, most deserved my love. I buried myself under the bedclothes and struggled with the hellish impulse till the bed shook. It still gained strength. I sprang up, clung to the bedpost and sunk my teeth, in the agony of despair, into the hard wood. It was uncontrollable. I shut my eyes, bowed down my head for fear that I should see her, and rushed out of the house. . . .

ANONYMOUS, *THE PHILOSOPHY OF INSANITY—BY A LATE INMATE OF THE GLASGOW ROYAL ASYLUM FOR LUNATICS AT GARTHAVEL* 17 (1947).

engage in behavior destructive to themselves and others, or that treatment could give them some appreciation of their conflicts and maladaptations which might modify their interactions with themselves and others.⁴⁸

It is difficult to define the ambit of mental illness associated with "dangerousness" and "being in need of treatment" for purposes of coerced confinement-treatment, as compared to the ease of relating examples which illustrate that society grants the right to "normal" persons to pursue a course of self-destructive action.⁴⁹ Psychoanalytic evidence suggests that the behavior of all men is influenced by forces beyond their conscious awareness which can lead to self-destruction or the destruction of others. If all men share such common characteristics, why distinguish between the "mentally ill" and the "mentally healthy"? There are no easy answers. A retreat to diagnostic labels, such as "psychosis," does not resolve the problem though it will limit the number against whom deprivations of liberty can be invoked.

The crucial first determinant of the group for which coercion is justified on therapeutic grounds⁵⁰ is not the ubiquitous presence of unconscious determinants affecting behavior, but the extent to which

⁴⁸ The acutely disturbed schizophrenic person finds that much that is in his awareness is no longer familiar to him; his thinking is disordered by the presence of vague, poorly organized symbols of previous anxiety-fraught interpersonal relationships. The referents and meaning of these symbols are unclear and cannot be communicated to others. As communication fails isolation increases, and the sufferer finds himself caught in a nightmare, driven by a feeling of urgency to make sense of the incomprehensibles with which he is involved. He seeks a simple formula to make all clear, and if he is unfortunate he may elaborate the paranoid solution with its grandiosity, apportioning of blame, and chronic reformulation of the past and present to refine and protect a "system" that will reduce anxiety. The cost of such a caricaturing of human living is high—for the patient and anyone with any vestige of interest in him. When the ties of human relatedness are poorly developed and fragile, despair may enter the scene . . . formal relationships are abandoned along with hope, and the organism becomes its own object and the referent for poorly organized symbols of interpersonal affairs. Here anxiety may be held in check through the maintenance of disorganization

I could wish that the young person en route to the schizophrenic revelation might have the opportunity of forming a relationship with someone not repelled by his anxiety, hesitancy, hostility, and autism. I should recommend psychotherapy for such a person prior to his experience of extreme withdrawal and panic, but in doing this I should recognize that he might reject or see no need for the proffered help, and that in most instances no one recognizes or admits the need until it is manifest to everyone except, possibly, the closest relatives.

Will, *supra* note 23, at 22-23.

⁴⁹ See, e.g., Justice Robert H. Jackson's choice following his severe heart attack:

As Solicitor General Simon E. Sobeloff recalled in his memorial tribute, Jackson's doctors gave him the choice between years of comparative inactivity or a continuation of his normal activity at the risk of death at any time. Characteristically, Jackson chose the second alternative, and suffered a fatal heart attack shortly thereafter. No court interfered with his decision. . . .

Dershowitz, *The Psychiatrist's Power in Civil Commitment*, PSYCHOLOGY TODAY 43, 46 (Feb. 1969).

⁵⁰ This group, of course, is also defined by a judgment of being "dangerous" to themselves and others. It is beyond the scope of this article to analyze the problems posed by commitments on the basis of "dangerousness."

unconscious forces have overwhelmed consciousness.⁵¹ This clinical judgment is difficult to make, but the cost of avoiding it is to allow everyone, *without exception*, to deteriorate no matter what the distortions in his inner and outer world. The group to be hospitalized is not, however, defined solely by such a judgment. Except for purposes of preventive detention, it must also rest on the expectation that treatment can modify behavior in a specified period of time. The vagueness of these formulations must be acknowledged because they invite the possibility for abuse and inevitable error which only carefully drawn rules and procedures can minimize. If the inability to promulgate *precise* standards suggests the proscription of all coercion, such an extreme recommendation contradicts human feelings and clinical judgment as well. At the same time it is clear that at present the ambit of coercion is too widely drawn and must be narrowed considerably.

Beyond the problems of distinguishing between "mental illness" and "mental health" for purposes of hospitalization, another oft-made argument must be considered. It asserts that no matter what the balance of instinctual and ego forces or of libidinal and destructive superego forces or of inner and outer world distortions, persons should be left

⁵¹ Psychoanalytic theory as described two levels of psychic functioning: the primary process and the secondary process. The contrast between the two has been detailed by Schafer:

Thinking, under the domination of the primary process, tends to be unreflective, timeless, and concrete; under the domination of the secondary process, thinking is reflective, shows time perspective, and uses abstract concepts corresponding to reality relations. Concerning *memory* in particular, domination by the primary process means that available memories are organized around the imperative drive or drives, while other memories, not relevant to immediate drive pressures, are unavailable; the contrast to this is the conceptual and reality-oriented organization of memories and their free availability, depending on the needs of the real—external as well as internal—situation. . . . Looked at from the standpoint of the *self*, primary-process functioning tends to eliminate the boundaries and inner coherence of the self so that what is thought and what is real are confused, the wish is equivalent to the deed, fantasies are events, and past ego states are present, contradictory selves; secondary-process functioning maintains the boundaries and coherence of the self in these respects. From the standpoint of *defense*, the contrast is one of the weakness (consciousness overwhelmed by normally unconscious impulses, affects, and fantasies) versus strength. . . . From the standpoint of the *ego as a whole*, the contrast is one of passivity versus activity, respectively, discharge of impulse occurring relatively independently of the ego, or the ego being unable to modify the damming up of impulses . . . versus impulses being discharged by means of the ego's controlling and executive apparatuses

Obviously, the contrasts drawn represent ideal polar positions. Any specific behavior must be assessed in terms of its relative position with respect to these poles or in terms of the particular admixture of primary and secondary processes in it. There are all degrees of transition. . . .

Schafer, *Regression in the Service of the Ego: The Relevance of a Psychoanalytic Concept for Personality Assessment*, in *PROJECTIVE TESTING AND PSYCHOANALYSIS* 88-89 (R. Schafer ed. 1967). Such evaluations are difficult but not impossible, especially if thoughtful models for diagnosis, like the one proposed by Schafer, are employed. They at least can systematize more precisely what has and has not been ascertained about a person's functioning and specify better the degree of incapacity.

to pursue their own fate if they so "state." Such a proposition can be as destructive of human life as its opposite of over-readiness to hospitalize. It is more difficult to pursue a middle ground, which seeks to take into account the complexities of conscious and unconscious dynamics and at the same time attempts to keep such judgments from running wild, but it is truer to the realities of human existence and aspirations. It is always easier to cut than untie Gordian Knots. Without coercion, society will abandon many people to their self-destructive and uncared-for fate. Such an approach is as insensitive as the abuse of power that leads to indefinite incarceration without treatment and with treatments that are of no value or ineffective or even harmful.

Most persons whom society involuntarily commits are consciously and unconsciously so convinced that no one cares, indeed they look at offers of help with such suspicion, that a sustained period of exposure to an unaccustomed world of trust, respect, and care is required in order to attempt to modify these beliefs.⁵² It is possible, without precisely knowing when it is and when it is not, to change defiant, ignorant, and fearful attitudes about treatment through patient and persistent efforts in an institutional setting. Behind the conscious refusal of treatment, other unconscious wishes also operate—to be protected, to be cared for, to be sustained, to be helped. What weight should be given to these wishes when they are almost drowned out by words which damn their own self and the world?

The persons whom society involuntarily commits, and wishes to treat, cannot be treated without coercion. Any uneasiness about coercion will never completely fade away. It can only partially be quieted by stating its purpose: eventual greater intrapsychic freedom for a person against whom such restrictions are initially invoked, though on other grounds.⁵³ For any deprivation of liberty must first be based on value preferences about society's tolerance for deviant behavior, and such value preferences are difficult to promulgate. Only in conjunction with societal judgments about intolerable behavior can

⁵² Sechehaye has described how the person suffering from schizophrenia "needs time, time to learn to believe again in living, to renew his confidence in others; slowly to describe a silhouette, the therapist, which gradually detaches itself from chaos and takes form in his opaque, unstable, disorganized universe." M. SECHEHAYE, *A NEW PSYCHOTHERAPY IN SCHIZOPHRENIA* 186 (1956).

⁵³ "When I become the therapist of a coerced person . . . I can do no better than curtail his freedom, being aware of some of the costs and risks in so doing. I agree that I am coercive, and that, oddly enough, I so act in the pursuit of freedom. There is not much to say about all of this; words will not allay a distrust and fear of the enforcer." Will, *The Reluctant Patient, The Unwanted Psychotherapist—and Coercion*, 5 *CONTEMPORARY PSYCHOANALYSIS* 1, 30 (1969). This article by a psychoanalyst discusses with great sensitivity the many problems which coercion raises for the patient, therapist, family, and hospital.

a value preference for greater intrapsychic freedom justify involuntary commitments for therapeutic purposes. However, once it is posited as an important consideration, restraint and treatment can also be evaluated in terms of its effects on such a goal. The emphasis on external behavior highlights again the crucial role which law must play in defining the psychiatrists' authority to invoke and administer the therapeutic process. What follows bypasses this problem, posits such authority, and instead asks questions about the administration of therapy.

III. TREATMENT AND COERCION—WITHIN WHAT LIMITS?

The use of coercion within a framework of a right to treatment could serve two purposes: (1) to prepare a person for exercising his right to treatment and (2) to treat a person even over his conscious objections. Since coercion has a life of its own, and if left unwatched can destroy those who live in its shadow, any use of coercion must be surrounded by safeguards for the individual. What follows is a discussion of four basic questions about the limits on the administration of therapy.

A. *The Duty to Be Treated and to Treat—For What Period of Time?*

Psychotherapy and milieu treatment, unlike therapies that can be administered against a patient's will, will fail if patients eventually do not develop some appreciation of the need for hospitalization, for exploration of their reactions to internal and external pressures as well as for sharing their conflicts and aspirations with the therapeutic community. All psychotherapies require the establishment of a collaborative relationship between patients and therapists;⁵⁴ they differ only with respect to the quality of this relationship. It need not be an unequivocally positive one.⁵⁵ Highly ambivalent reactions have been

⁵⁴ "Any comprehensive treatment plan to be effective requires a degree of cooperation by the patient Almost any form of conventional psychotherapy is extremely difficult to administer without cooperation, and it may be said in general that the effectiveness of the psychotherapies is proportional to the degree of cooperation that is present" 1967 *Position Statement*, *supra* note 37, at 1459.

"A solid working relationship in which the participants develop a sense of mutual trust is unquestionably a sine qua non for all forms of psychotherapy. In its absence there can be no successful psychotherapy. . . ." Strupp, Wallach & Wogan, *PSYCHOLOGICAL MONOGRAPHS* 82-83 (1967).

⁵⁵ This does not refer to the negative transference reactions to therapists that can evolve into doubts about and rejection of treatment even in voluntary therapeutic relationships, but, instead, to the occasional or constant resentment of treatment in enforced settings that are associated with a simultaneous willingness to accept the imposed restrictions. For a discussion of negative transference, see R. GREENSON, *THE TECHNIQUE AND PRACTICE OF PSYCHOANALYSIS* 233-7 (1967).

observed in patients, both in private and public mental institutions, and they create difficult problems for the thoughtful therapist. On the one hand, the therapist expects that the patient will benefit from remaining in treatment (or "become worse" if he leaves); yet, on the other hand, it seems to require the therapist's explicit or implicit threat of non-release in order to support one side of the patient's ambivalence. Such interventions create problems. The threats themselves can be anti-therapeutic, though this will not become clear for some time, and perhaps never. Some persons, who are either unwilling or unable to accept treatment, may never become patients, but under the threat of indefinite hospitalization, cannot admit this to themselves or their therapists.

The therapeutic problems created by coerced treatment and by the psychological incapacity of patients to accept, at least initially, an offer of help suggest the imposition of a "duty to be treated" only for a limited period of time. The imposition of time limits will preclude *indefinite* postponement of resolving the constitutional issues of confinement and the psychiatric uncertainties about treatability. Psychotherapeutic interventions could then be restricted to an exploration of resistances to treatment and thus would extend only to an opportunity to learn to appreciate the value of treatment and those who offer it. Put another way, the period of coerced treatment could be limited to an opportunity to acquire, if possible, the capacity to decide for or against treatment. The employment of organic treatment modalities, an even more troublesome issue, could be restricted to interventions which either quickly return a person to his prior functioning, leading to release, or restore his ability to make decisions about further treatment. Such time limits might vary with the kind of "mental illness" and the kind of "dangerousness," but this possibility requires more detailed exploration.

The imposition of time limits will suggest to both patient and therapist that the day will arrive when both will have either to bow to the strength of unconscious forces that prevent therapy or to respect the conscious and unconscious convictions that deny its necessity.⁵⁶ Until that point is reached, the explorations between patient and therapist will be more explicitly in the service of establishing the *preconditions*

⁵⁶ Time limits will facilitate the establishment of a therapeutic atmosphere which psychiatrists should welcome. No therapeutic community can function optimally with persons who are indefinitely condemned to treatment they do not want or from which they cannot benefit. Eventually, all members of these communities will be affected by the confusing presence of therapists and jailors, patients and prisoners in their midst. Moreover, psychiatrists will be relieved of the lifelong burden, which surprisingly enough they have been all too willing to assume, to treat when treatment is neither welcome nor makes sense.

for the exercise of a right to treatment. The participants will know that the task before them is to reach consensus or to respectfully differ on the need for treatment. Psychiatrists will then be more aware than now that they need not and should not feel obliged to "treat" immediately. Rather they are to reflect to a person whatever impressions they have gathered about the need for treatment and the variety of ways in which the person reacts negatively to this suggestion. This is itself a therapeutic task, indeed, initially the only rational one, because it can at least clarify mutually opposing objectives and the consequences of their implementation. Most of all, therapists and patients will not engage in an abrasive encounter of imposing the resisting treatment, but will concentrate on seeking to understand their differences of opinion and their determinants. The power of the therapist, which confines not only the patient but the therapist as well,⁵⁷ will be diminished and he will be able to work more clearly in the role traditionally assigned to him. The reality of the coercion will be constantly before therapist and patient and will not be bypassed but confronted as the major issue that needs to be settled.

Such an atmosphere can only be created if the participants are informed about the consequences of declining the right to be treated and to treat. This is a judicial and legislative matter, and lawmakers must promulgate rules and procedures adequate to this task. For example, what will be the consequences for those who do not wish to or cannot exercise the right to treatment? Similarly, what will be the consequences of unwillingness or inability to treat? Under what circumstances will it lead to release, to transfer into the penal system, or to indefinite custodial⁵⁸ commitment within what kind of hospital environment? Procedures must be established which affirmatively eliminate treatment as the major reason for hospitalization and lead either to release or to the invocation of other legal justifications and proce-

⁵⁷ "In hospital work we run the risk of losing our perspective about freedom; it becomes too easy to lock people up, and in doing this to become locked in ourselves. In a sense the psychiatrist can be no more free than his patients." Will, *The Reluctant Patient, The Unwanted Psychotherapist—and Coercion*, 5 CONTEMPORARY PSYCHOANALYSIS 1, 26 (1969).

⁵⁸ Frankel points out: "Since it has been thought that the only justification for preventively detaining a dangerous person was the possibility of treatment, there has been a tendency to fictionalize the notion of treatment." Frankel, *Preventive Restraints and Just Compensation: Toward a Sanction Law of the Future*, 78 YALE L.J. 229, 253 (1968). "Environmental therapy" or "milieu therapy" have often been labelled treatments when instead, they are only employed for custodial care. The real test of treatment is at least some collaboration between patient and therapist, and milieu therapy should also be defined by this criterion. Otherwise, however "beneficial" the hospital environment, "treatment" is only another form of custodial care and should be so identified.

dures for continuing detention.⁵⁹ Whatever the promulgations, they will have to be clearly articulated so that they can be subjected to relentless scrutiny.

Thus the first task of law and psychiatry is to limit the duty to be treated and to create a right to treatment only for those who wish to exercise it or who after a period of time have come to appreciate such a right and can benefit from it. For all others the right is a delusion,⁶⁰ an unwarranted denial of their constitutional rights and an attempt to substitute treatment for detention.

B. *Selection of Treatment—By Whose Authority?*

In current practice, a person who is involuntarily sent to a mental hospital is, by virtue of this status, considered subject to treatment. Questions have rarely been posed "whether the committed person [is], in any meaningful sense, a patient at all"⁶¹ or what authority should be delegated, and to whom, for making therapeutic decisions. The right to treatment will sooner or later be tested in the courts with allegations that some forms of treatment are "cruel," "inferior," "experimental," "unsuccessful," or that persons have not "consented" to their administration. Surely it will be argued that a patient's right to treatment encompasses a right to select and reject certain kinds of treatments or, in the alternative, that a duty to be treated does not necessarily preclude his participation in the selection of treatment.

Psychiatry has at its disposal a variety of therapeutic techniques ranging from lobotomy to electroshock, tranquilizers, hypnosis, suggestion, exhortation, behavior therapy, reeducation, and a variety of nondirective psychotherapies. They can be employed on an individual,

⁵⁹ Again it should be emphasized that there may be a need for preventive detention of some mentally ill persons considered sufficiently dangerous to themselves or others. If so, deprivations of liberty for such purposes should be explicitly acknowledged so that rules and procedures will be established whose constitutionality can be constantly reexamined. See also Morris, *Impediments to Penal Reform*, 33 U. CHI. L. REV. 627, 643 (1966): "... there is a clear difference between the medical, social welfare, psychiatric, and child care functions of the state and its police and correctional functions. There is too much confusion of purposes and too frequently a sacrifice of justice when we combine the several justifications the state may have for taking power over a citizen's life and in so doing expunge or attenuate the existing limitations and controls of power that each has developed."

⁶⁰ "The evidence is sufficient to support the finding of the court that appellant was a mentally disordered sex offender not *amenable* to treatment but still a danger to the health and welfare of society. As such he may be dealt with by *compulsory treatment*, involving quarantine, confinement or sequestration." *People v. Rancier*, 240 Cal. App. 2d 579, 585, 49 Cal. Rptr. 876, 881 (Ct. App. 1966) (emphasis supplied).

⁶¹ Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782 (1969).

group, and/or milieu basis.⁶² Before too long it may be possible to implant electrodes in the brain and control behavior by periodic stimulation of specific central nervous system areas.⁶³

Within these therapeutic approaches two models of therapy can be distinguished: the psychotherapeutic and the organic. While both models share the possibility of being employed in the service of social control and subversion of a patient's way of life, the patient can resist the impact of such applications in psychotherapy to a considerable extent, or even completely, especially if he wishes to do so. If, in addition, any psychotherapy that includes covert but deliberate manipulations of human behavior is proscribed, the opportunity for unilateral attempts at social control or uninvited subversion is further reduced.⁶⁴

⁶² See generally J. FRANK, *PERSUASION AND HEALING—A COMPARATIVE STUDY OF PSYCHOTHERAPY* (1961).

⁶³ T. DELGADO, *EVOLUTION OF PHYSICAL CONTROL OF THE BRAIN* (1965) (presented as the James Arthur Lecture on the Evolution of the Human Brain, American Museum of Natural History).

⁶⁴ One example will speak for many:

This study concerns an evaluation of the use of faradic shock as punishment for the purpose of suppressing the violent, potentially homicidal behavior of a hospitalized, chronic paranoid schizophrenic patient. The uniqueness of the study lies in . . . c) the fact that this procedure was administered against the expressed will of the patient . . .

* * *

Three factors contributed to our choice of a punishment treatment paradigm: a) the dangerousness to self and others of the patient's behavior, b) the inability of previously employed treatment methods to modify this behavior and c) the far more drastic nature of other possible treatment alternatives.

* * *

[T]he management of this patient represented a serious medical-psychiatric problem and something had to be done before she killed someone or was seriously injured or killed herself through the retaliation of another patient. Faced with the ineffectiveness of prior treatment approaches, we were forced to consider other more extreme procedures, such as prefrontal lobotomy, shackling her in physical restraints, or isolating her through prolonged seclusion. We were naturally reluctant to resort to these procedures and believed it would be far more humane and potentially therapeutic to try to modify her behavior through aversive conditioning. After securing the support of a group of board-certified psychiatrists and obtaining the necessary administrative clearance, we initiated the treatment program.

* * *

There were a number of reasons for choosing the cattle prod as the means of delivering the aversive stimulus or punishment. From a technical standpoint, this instrument . . . seemed to represent an excellent device for providing a potent, noxious stimulus. . . . From the standpoint of safety, the shock caused no tissue damage or other adverse physical effects. . . .

Although we were able to establish "effective" control over the intensity, duration and frequency of aggression and its antecedents, these behaviors were never eliminated completely and, therefore, control over them could not be regarded as absolute. Throughout the entire treatment program, there were occasional flareups of each of the three levels of punishable behaviors. . . .

* * *

From several of the patient's statements, such as "If I can't fight you guys, I'll join you. . . . Nothing else works," we might also invoke the mechanism of "identification with the aggressor." With such a view, we would expect that the patient, feeling impotent and frightened when having her habitual sources of displaying power over others blocked, would attempt to regain strength and

Psychotherapeutic techniques, to be successful, require the cooperation of the patient though the nature and quality of this cooperation is not precisely known. The organic therapies, on the other hand, can bring about changes, even radical changes, in a patient's behavior without his cooperation. They can make him docile and agreeable to subsequent interventions that are at least in part the result of the effects introduced by chemical or physical agents. They can cause alterations in behavior that are reversible and irreversible.⁶⁵ However, the crucial distinction between the two models is that "therapeutic benefits" or "therapeutic harm" can be conferred in the psychotherapeutic model only with the collaboration of the patient and, in the organic model, even in its absence.

A right to treatment does not pose for the first time questions about selection of treatment. These questions should have been asked a long time ago. The explicit promulgation of such a right only brings them into sharper focus: Should some or all of the therapeutic modalities be utilized only if patient and/or family and/or guardian and/or court have authorized their use? As long as a person has not agreed to become a patient, should any of the organic methods of treatment be employed, if there is reasonable likelihood that even without his cooperation they will "benefit" him? Should such organic methods of treatment be restricted to procedures which do not cause irreversible brain damage? What consequences should follow if patients are willing to participate in some forms of treatment but not in others when the preferred treat-

security through her identification with the staff. In support of this thesis, we recorded a number of instances where the patient, in the presence of one or another staff member, mentioned that she felt secure with them and that she preferred to be with them so that she could learn once again how to behave normally.

Perhaps the most straightforward explanation for the increase in the patient's social approach behavior related to the obvious change in attitudes and behavior of the staff and fellow patients toward her once her aggressive tendencies were reduced. . . . With this threat of harm diminished, the staff could be more genuinely affectionate, thereby increasing the possibility that the patient could respond in kind. In any case, no matter what mechanisms or combination of mechanisms were instrumental in the patient's movement toward socialization, we would again underscore our impression that it was first essential to neutralize her aggressive potential.

* * *

Another factor contributing to the relative success of the aversive therapy program seemed related to the subjective meaning of punishment for the patient. From clinical observations, we had become convinced that the patient, at some level of consciousness or volition, wanted to be effectively controlled and have limits set and enforced. In the course of our therapy program, we collected much anecdotal "evidence" that seemed to support this view. . . . "I know what you're trying to do. . . . You're trying to make a human being out of me."

Ludwig, Marx, Hill & Browning, *The Control of Violent Behavior through Faradic Shock*, 148 J. NERVOUS & MENTAL DISEASE 624, 625, 626, 635, 636 (1969).

⁶⁵ For a discussion of physical therapies, see S. ARIETY, *INTERPRETATION OF SCHIZOPHRENIA* 480-7 (1955).

ments are not available at the institution? What choices should be delegated to patients who seek a treatment considered "inferior" in terms of its long-term results but "superior" in terms of returning a patient more quickly to improved social adaptations, though the expectation is that such improvements may not last? Who are the ultimate decision-makers on the treatment of choice for patients who do not have the freedom to select their own therapeutic environment?

Psychiatry, like medicine, has had little experience with establishing a collaborative relationship between physicians and patients for the many medical decisions that affect patients. The prevalent practice is still for the physician to use his "best judgment" and to impart little information to the patient about alternative methods of treatment, consequences, inconveniences, risks, prognosis, or even the experimental nature of many interventions. The doctrine of "informed consent" is gradually making inroads on such practices, but its application has been tempered by positing an "implied consent" to any intervention once a patient chooses to consult a physician. However, little, if any, choice of physician or type of therapy exists in state-imposed therapies. In the context of a right or duty to be treated, the presently unrestricted option to impose any treatment, particularly experimental procedures, therapeutic techniques with uncertain predictive consequences, and treatments which aim for social control, can no longer be left to the sole discretion of the mental health profession.

C. Duration of Treatment—How Long?

The decision to release a "mentally ill" person generally rests on three criteria: his "mental condition," the likelihood of "danger to himself or others," and "being in need of treatment." The vagueness of definition, which has been the fate of these criteria, has created much confusion in the dialogue between psychiatry and law. The attack, engendered by this confusion, has mostly been directed against the uncertainties and deficiencies in psychiatric knowledge and less against the unclearness of the legal questions posed to psychiatrists. At the same time, psychiatrists have answered questions all too readily without reflecting whether meaningful answers could be given. The "science" of psychiatry, however, is sufficiently advanced to convey the complexities inherent in decisions to release: cures of "mental illness" are difficult to come by; the subsequent course of a remission cannot be readily predicted; conflicts which led to "dangerous" propensities can suddenly or gradually emerge again, depending in part also on changes in unpredictable external conditions; and extrapolations from hospital adjustments to adjustments outside the hospital are hazardous.

More important, though, is the fact that judgments about recovery from "mental illness" and "dangerous" propensities can at best point to probabilities. Only in intensive individual encounters between therapist and patient can both, at times, get a sense of conviction that meaningful therapeutic work has led to insight and better control. Such opportunities will not prevail in mental hospitals for a long time, if ever. Moreover, in involuntary settings the quest for release will consciously and unconsciously support a patient's defensive convictions about being in "better" control than he actually is and this will make any evaluation even more uncertain. These tentative judgments which can, of course, be surrounded with more definitive statements about a person's psychological functioning are often not welcomed by legal decision-makers. Psychiatrists must resist yielding to the pressure for "certainty" because it only compounds the confusion. The uncertainty is a reflection not only of the state of psychiatric knowledge but also of psychological existence.

Duration of treatment should not depend on the patient's mental condition or dangerousness, but his willingness to continue treatment. With patients who have accepted treatment and with whom a therapeutic alliance has been established it should be possible to review, whenever necessary, indications and contra-indications for release and to explore whatever differences in opinion may emerge. Should this lead to a break in the therapeutic relationship and a refusal to accept further therapy, either release or preventive detention would then be a consequence.

Much thought has to be given to establishing rules and procedures that will facilitate the therapeutic process. In the course of treatment patients will benefit from opportunities to be at large for varying periods of time, to work, play, and study. The system must make flexible provisions to support such endeavors. It may be possible gradually to shift patients from in-patient to out-patient treatment, perhaps first with and later without supervision by the court, and such changes in status should be encouraged rather than impeded.⁶⁶ Finally, duration of treatment has never been tied to specific time limits and the question should be explored whether therapy will be facilitated by setting maximum time limits for in-patient therapy at the beginning of treatment.

D. *Supervision by Courts—What Kind?*

In *Rouse v. Cameron* and subsequent cases the District of Columbia

⁶⁶ See *Covington v. Harris*, No. 21,935 (D.C. Cir., March 14, 1969); *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966); *Hough v. United States*, 271 F.2d 458 (D.C. Cir. 1959).

Circuit Court of Appeals has begun to set forth criteria for adequate treatment: (1) "The hospital need not show that the treatment will cure or improve him but only that there is a bona fide effort to do so. . . .";⁶⁷ (2) "The effort [must] be to provide treatment which is adequate in light of present knowledge, [though] the possibility of better treatment does not necessarily prove that the one provided is unsuitable or inadequate. . . .";⁶⁸ (3) adequate number of psychiatric personnel;⁶⁹ (4) "initial and periodic inquiries [must be] made into the needs and conditions of the patient with a view to providing suitable treatment for him, and that the program provided is suited to his particular needs."⁷⁰ These criteria, except for (3), are so vague that only further judicial construction may clarify their meaning. If the person's willingness to participate in treatment is accepted as an important precondition for treatment, adequate treatment would also be defined by such express agreement. Evaluation of adequate treatment will then include, as its most important determinant, the person's own reaction to treatment. Whether such reaction is the result of the person's incapacity or the lack of facilities for treatment could still be determined, but at least the patient's own feelings would not be overlooked, as they so often are, but included as an important criterion.⁷¹

The court's efforts raise questions about the nature and extent of judicial supervision of the right to treatment. Commentators have already cautioned that in individual cases "it is hard to see what ma-

⁶⁷ 373 F.2d at 456-7. In *Tribby v. Cameron*, 379 F.2d 104 (D.C. Cir. 1967), Judge Edgerton added: "We do not suggest that the court should or can decide what particular treatment this patient requires. The court's function here resembles ours when we review agency action. We do not decide whether the agency has made the best decision, but only make sure that it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion." *Id.* at 105.

⁶⁸ 373 F.2d at 456-7.

⁶⁹ *Id.* at 458.

⁷⁰ *Id.* at 456.

⁷¹ If the patient's capacity for treatment were to be given recognition, the district judge in *Clatterbuck v. Harris*, 295 F. Supp. 84 (D.D.C. 1968), might not have remanded the petitioner to the custody of the Superintendent of Saint Elizabeths Hospital with the order that he "is to continue to make the appropriate treatment available." *Id.* at 86. The court had already stated:

The evidence is clear that Petitioner is not being given therapeutic treatment which is adequate for his condition. However, it also indicates very clearly that the only effective treatment in his case is psychotherapy. Psychotherapy requires that the patient participate in the process whereby he can recognize the nature of his problem. Petitioner refuses to discuss his problem or participate in any fashion in the very course of treatment most effectively used and recommended for those in his condition. . . . Thus, while treatment is not being given, the fault lies with the patient, not with the institution To allow him to refuse treatment and then to use that refusal as the basis for the allegation that he is not being given treatment and thus should be released . . . would be an anomalous result indeed. . . .

Id. See also *Eidinoff v. Connolly*, 281 F. Supp. 191, 199-200 (N.D. Tex. 1968).

terials would guide a court in a truly rigorous evaluation of a course of medical treatment.”⁷² While such evaluations will remain an unavoidable task in habeas corpus proceedings, courts could begin to focus their attention more profitably on an appraisal of the overall treatment program of institutions. It will not only give the courts a broader perspective against which to evaluate individual claims about inadequate treatment but also create the opportunity for a continuing dialogue between judges and hospital administrators about the conditions that must be met so that “the ‘adequate treatment’ standard will [not] be applied as a ‘some treatment’ standard”⁷³ for most patients.

Courts could promulgate and ask hospitals to promulgate standards for adequate patient-staff ratios, adequate availability of a variety of treatment modalities, and, most important, a philosophy of treatment. In formulating a philosophy of treatment, answers should be provided for the questions raised in this article: What therapeutic techniques are prescribed and proscribed for encouraging persons to become patients? What treatment modalities are employed, with or without consent, before and after a person has agreed to be a patient? What considerations will lead to a termination of efforts to treat or of an already established therapeutic relationship because persons are unwilling to be treated or unable to benefit at all, or any further, from treatment? What procedures have been established to inform the court that treatment has been successful or has failed? A continuous review of such policy statements by courts and the mental health profession can only benefit those persons for whose care law and psychiatry are jointly responsible.

IV. EPILOGUE

Promulgation of a right to treatment is, of course, not enough. Institutions are required which can implement it. There is no reason to believe that mental hospitals will be adequately financed or staffed, at least for a long time to come, to provide adequate treatment. The District of Columbia Circuit Court of Appeals intimated that absent adequate treatment “[u]nconditional or conditional release may be in order.”⁷⁴ But it is doubtful that either judges will release the many persons who will continue to receive inadequate treatment or that legislators will permit such a judicial response if it were to be implemented on a large scale. It is equally unlikely that legislatures, in the light of other priorities, will allocate the resources which a call for

⁷² 80 HARV. L. REV. 898, 900 (1967).

⁷⁴ 373 F.2d at 458-9.

⁷³ *Id.* at 901.

adequate treatment demands. This reality must be acknowledged and considered in any reform lest the greatest merit of *Rouse v. Cameron* come to naught from the beginning. The opinion, like so many of the District of Columbia Circuit Court of Appeals', has started another great debate, already reflected in case and commentary, and law and psychiatry can only benefit from the inevitable jarring of the "cakes of custom." However, if the realities of the problems which the implementation of a right to treatment faces, including the limitations of judicial power and competence as well as psychiatric capability and competence, are not confronted, then the danger is great that rhetoric will distort the vision of decision-makers and see solutions where there are none.

If after a respectful effort to engage a person in treatment, the right to treatment will not be limited to those persons who wish to avail themselves of it, the risk is great that overzealous advocacy of the right to treatment, though based on good intentions, will lead to further neglect of constitutional rights and therapeutic practices. In all calls for reform, and especially those which result from dissatisfactions with practices that over generations have become deeply ingrained in the life of the community, there is the danger that after implementation of reform, the same abuses will emerge again in new, though initially disguised, forms. This surely has been the case with respect to the care of the mentally ill and particularly those who are also suspected of criminal activities. The "largely unconscious feelings of apprehension, awe and anger toward the 'sick,' particularly if associated with 'criminality' . . . must be recognized [in our] enormous ambivalence toward the 'sick' reflected in conflicting wishes to exculpate and to blame; to sanction and not to sanction; to degrade and to elevate; to stigmatize and not to stigmatize; to care and to reject; to treat and to mistreat; to protect and to destroy."⁷⁵ The history of mental hospitals is filled with examples that illustrate this point. In 1842 Charles Dickens had this to say of the Institution of South Boston which later became the Boston State Hospital:

The State Hospital for the insane [is] admirably conducted on those enlightened principles of conciliation and kindness which twenty years ago would have been worse than heretical. . . .

* * *

Every patient in this asylum sits down to dinner every day

⁷⁵ Katz & J. Goldstein, *Abolish the Insanity Defense—Why Not?*, 138 J. NERVOUS AND MENTAL DISEASE 57, 65 (1964) (also published in slightly altered form in 72 YALE L.J. 853 (1963)).

with a knife and fork; and in the midst of them sits the gentleman (the superintendent). . . . At every meal, moral influence alone restrains the more violent among them from cutting the throats of the rest; but the effect of that influence is reduced to an absolute certainty, and is found, even as a means of restraint, to say nothing of it as a means of cure, a hundred times more efficacious than all the strait-waistcoats, fetters, and hand-cuffs, that ignorance, prejudice, and cruelty have manufactured since the creation of the world.

In the labour department, every patient is as freely trusted with the tools of his trade as if he were a sane man. . . .

It is obvious that one great feature of this system is the inculcation and encouragement, even among such unhappy persons, of a decent self-respect.⁷⁶

This pleasant scene did not survive either in Boston or elsewhere on the American institutional scene and was soon followed by a period of rejection of the mentally ill. Today the "therapeutic community," "milieu treatment," and "the right to treatment" represent a rediscovery of the world of Dickens. Unless this right is thoughtfully advocated, there is every reason to believe that it will be short-lived. The right to treatment, which has emerged from, but also is rooted in, a setting of enforced confinement, is particularly vulnerable to corruption by coercion. The outcome of this corruption will be neglect of the individual. To protect the individual, all points in the therapeutic decision-making process where neglect outweighs care must be identified, and the question must be posed and answered: how can neglect be minimized? Finding this answer is a never ending task which cannot be petrified by final solutions.

⁷⁶ C. DICKENS, *AMERICAN NOTES* 61-64 (Peter Smith ed. 1968).